

## Filing TRICARE Standard Claims for Retirees and their Dependents In the Philippines

### It's Important to Fill Out A Claim Form Correctly

The TRICARE claims processing contractor for the overseas regions receives thousands of claims every day. These claims are computer-processed to facilitate reimbursement for TRICARE-covered medical procedures and services. Any mistake, forgotten signature, or other missing information can slow down your claim because the contractor may deny your claim for lack of needed information.

### Which Claim Form to Use

Overseas health care providers complete and submit the **HCFA 1500** claim form for care given to a TRICARE-eligible beneficiary. As a provider you may obtain a copy of this form on the Internet at <http://www.tricare.osd.mil/claims/1500-90.pdf>. You can also get forms from the TRICARE Area Office – Pacific by email at [tpao.csc@oki10.med.navy.mil](mailto:tpao.csc@oki10.med.navy.mil), or phone at (81) 6117-43-2036. Additionally, you can request the claim form from the TRICARE Management Activity, 16401 E. Centretech Parkway, Aurora, CO 80011-9066.

### Complete the Claim Form

It is important to provide all relevant information regarding the patient and care provided. Although not an exclusive list, the below items are highlighted as they are critical to efficient processing of your claim:

#### **Box 1a and Box 11: Insured I.D. Number**

The TRICARE-eligible **sponsor's** U.S. social security number (SSN) must be entered in Box 1a and in Box 11.

#### **Boxes 2-8:**

Complete as indicated with beneficiary information. FOR boxes 1a, 4, 7, 11, and 11a: "Insured" refers to the sponsor's information.

#### **Box 9: Other Insured's Name**

Enter other insured's name if true or known in Box 9.

#### **Box 12 and Box 13: Beneficiary Signature**

Always include the TRICARE beneficiary's signature in Box 12 and 13.

#### **Box 17 and Box 17a: Treating Physician**

Always include the treating physician's full name and medical degree in Box 17. Include the WPS Provider number, if known, in Box 17a.

#### **Box 21: Admitting Diagnosis**

Admitting diagnosis is required on all claims and must be written or typed in Box 21.

#### **Box 24a: Date Services Were Rendered by Provider**

All dates of service must be entered in Box 24A, even for a single appointment date (for example, From: 07 | 01 | 05, To: 07 | 01 | 05.)

#### **Box 25: Provider Certification and Identification Number**

Enter the provider's identification number in Box 25, the same as Box 17a. If the provider has not yet been credentialed with TRICARE, the first claim initiates the certification process. Certification verifies the physician has valid credentialing and a physical facility location. After certification is processed and approved, TRICARE issues a provider identification number.

#### **Box 27: Accept Assignment?**

If the provider is to be paid, the YES block in Box 27 must be checked. If reimbursement is to be paid to the patient, check the NO block.

#### **Box 28 and Box 30: Total Charge and Balance Due:**

Enter total amount charged in Box 28 and balance due in Box 30.

#### **Box 31: Treating Provider's Signature**

Providers signature must appear in Box 31.

#### **Box 32 and Box 33: Name and Address of Facility Where Services Were Rendered and Provider's Address**

Enter the name and address of the facility where services were rendered in Box 32. To receive payment, this address must match the address that appears in Box 33, which shows provider's name, physical address, ZIP code and phone number. Both of these boxes must be filled-in. WPS will only reimburse to the physical location of the treating physician.

#### **The following boxes are not required to be completed:**

Box 10, Box 11b, Box 14, Box 15, Box 16, Box 18, Box 20, Box 22, Box 23, Box 24B, 24C, 24E, 24G, 24H, 24I, 24J, 24K, Box 26, and Box 29.

#### **Reimbursement Currency and Method of Payment**

Provider reimbursement will be in the currency of the physical facility location. Due to U.S. Federal law, reimbursement cannot be provided in the form of electronic funds transfer (EFT). In addition, benefit payment checks can only be mailed to the place of service identified on the claim in Box 32. No provider payments may be sent to any other address.

## Helpful Hints for Filing Claims

1. All receipts should be on (or attached/taped to) 8 1/2- by 11-inch sheets of paper.
2. Include the sponsor's social security number on ALL pieces of correspondence and attachments to claims.
3. Do not highlight information on documents with a "highlighter" or "magic marker." It is either lost in scanning or blackens the information you want to emphasize. Circle the information instead.

## What Goes in Along with the Claim?

One or more of the following may need to go in with the claim. If they are not provided to the TRICARE claims processor when needed, your claim could be denied or delayed. So read this section very carefully.

**Note:** When a provider files a claim on a beneficiary's behalf, the provider should be willing to provide the TRICARE beneficiary with all documentation submitted to the overseas claims processor for the beneficiary's records.

All attachments should be sent in with each claim, even if a claim was previously filed for similar services during the same course of treatment.

### • Fully Itemized Bills

A fully itemized bill—on the provider's stationary—that shows the cost for each service or supply provided. It must show the following:

1. Name of the patient
2. Diagnosis or description of symptoms
3. Each item of service or supply
4. Place of service
5. Number and frequency of each service
6. Date of care
7. Charge for each item of service or supply

Bills for prescription drugs must be on the pharmacy's letterhead or billing form, and must also show the following:

1. Name of the drug
2. Strength of the drug
3. How much of the drug you bought (the number of pills or amount of other medicine)
4. Cost of each drug (except prepaid prescription plans)
5. Prescription number and date prescription was filled (you should also include a copy of the actual prescription that was written out by your doctor)
6. Name and address of the prescribing doctor
7. Name and address of the pharmacy

## Where to Submit Claims Forms

Submit all documentation and completed and signed claim form(s) to the following address:

Wisconsin Physician Services (WPS) – Foreign Claims  
P.O. Box 7985  
Madison, WI 53707-7985 USA

**NOTE:** Claims must be submitted via mail; they cannot be submitted by fax or any other electronic means due to signature-validation requirements. Therefore, take every precaution to ensure that your claim reaches WPS.

For additional information, you can register online with WPS at <http://www.tricare4u.com/>. Once you have registered you'll be able to view patient **Eligibility** and amounts paid toward deductibles. Perform a quick **Claim Search** for: status, amount paid and **Explanation of Benefits (EOB)**. Registered providers can **Contact Customer Service** using our secured system.

If you have questions about processing or the status of a claim--and you chose not to register with WPS online--you may call:

WPS Claims Customers Service: 1-(608) 301-2310 / 2311  
TRICARE Area Office – Pacific: (81) 611-743-2036  
TRICARE Area Office-Pacific email: [tpao.csc@oki10.med.navy.mil](mailto:tpao.csc@oki10.med.navy.mil)

Attachments:

1. Sample HCFA 1500- WRITTEN INSTRUCTIONS
2. Sample HCFA 1500- SAMPLE PATIENT